

Seatone in arthritis

SIR,—In reply to the article by Dr E C Huskisson and others about Seatone, an extract of the green-lipped mussel *Perna canaliculus* in rheumatoid arthritis (25 April, p 1358), we would like to make the following comments.

(1) To our knowledge, no physician has claimed that one month on Seatone has any obvious effect on the majority of arthritic sufferers, and the term "course" on the bottle is, in our opinion, misleading. Like Dr Huskisson, we^{1,2} did not find a noticeable difference between the active preparation and the placebo at the end of one month. The numbers of patients improving on the active treatment, however, increased with time and, although not reaching significant values by three months, were significantly different by six months ($\chi^2 = 6.54$ and 6.06 for rheumatoid and osteoarthritic patients respectively; $p < 0.02$ to 0.01 in each case). If Dr Huskisson had wished to reproduce our trial conditions, it is difficult to understand why he carried out his double-blind study for only one month instead of three.

(2) We agree that the placebo figures are not tabulated for the three-month period in the trial report.¹ This occurred because the tables were shortened and simplified for publication. These data are now presented for the active and placebo groups of the rheumatoid and osteoarthritic patients in the table. These show that articular index, limbering-up time, and functional index all improved significantly in the rheumatoid group on active treatment and that pain as assessed by the visual analogue scale, functional index, and the time taken to walk 50 ft (15 m) improved significantly in the osteoarthritic group on active treatment. No significant improvements were obtained in any parameter in either placebo group.

(3) Prior to carrying out the double-blind trial, we had had over five years' experience with Seatone, and had noted that on discontinuing this substance patients could maintain improvement for periods ranging from several days to several months. For this reason, a complete double-blind cross-over trial over a short period is unlikely to provide useful information as patients receiving placebo in the cross-over period may still be benefiting from the active substance given in the first period of the trial.

(4) It is pertinent to re-emphasise that the group studied in our trial was somewhat atypical in that all the patients were on a surgical waiting list, having deteriorated to the stage where joint surgery was considered necessary. The average age was high, 56.7 years for the rheumatoid patients and 69.0 years for the osteoarthritic patients. Many of

them were over 70 years of age. None had heard of Seatone and all believed that only surgery could help them. This contrasts with Dr Huskisson's group, all of whom had heard of Seatone and had actually asked for this treatment. They thus entered the trial with high expectations of success. This in itself could account for the high proportion of placebo responders and it decreases the objectivity. Experience in Glasgow has shown that in rheumatoid arthritis the placebo effect is unlikely to last for longer than six weeks.³ This, coupled with the fact that Seatone can take from one to three months to have an effect means that, in our opinion, a double-blind trial should last for at least three months. Moreover, the dose used in this trial was 900 mg/day compared with 1050 mg/day in our study. Some patients require even higher doses and may need to alter their dietary habits (unpublished data).

We have been using Seatone for over seven years and have found it to be the safest and most effective preparation for both rheumatoid arthritis and osteoarthritis that we have yet come across. The title of Dr Huskisson's study "Seatone is ineffective in rheumatoid arthritis," is misleading in that it differs from his concluding remarks that Seatone is ineffective when given for only one month. It is unfortunate that such a valuable addition to the materia medica could be misjudged by this title.

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¹ Gibson RG, Gibson SLM, Conway V, Chappell D. *Practitioner* 1980;224:955-60.

² Gibson RG, Gibson SLM. *Lancet* 1981;i:439.

³ Rooney PJ, Capell HA, Paterson S, Buchanan WW, Dick WC. *Br J Clin Pharmacol* 1978;5:453-5.

Treatment of anaphylactic shock

SIR,—Your leading article on the treatment of anaphylactic shock (28 March, p 1011) prompts the following comment.

From a patient's point of view it might be appropriate to point out that adrenaline administered by inhalation is a convenient and effective method of self-medication in the emergency treatment of anaphylactic shock, particularly occurring after an insect sting. Three puffs from a Medihaler-Epi (Riker), which contains free adrenaline, immediately

after a sting, repeated 20-25 minutes later if necessary, has been suggested as a suitable dosage schedule.¹ Indeed, adrenaline administered by inhalation has been claimed to act more rapidly than that administered parenterally.²

Patients, particularly those threatened by anaphylaxis from insect stings, should be encouraged to carry a Medihaler-Epi for emergency use.

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¹ Ganderton MA. *Br Med J* 1979;ii:1216-7.

² Reid HA. *Medicine* 1978;7:341-6.

SIR,—My society welcomes the statement in your leading article (28 March, p 1011) that chiropodists should carry a supply of adrenaline, and in a submission to the medicines division of the Department of Health and Social Security in 1978 it asked that chiropodists who are trained to use local analgesia and hold a certificate of competence in its use approved by the Chiropodists Board should have available to them adrenaline injection BP for use in administration so long as the administration is for the purpose of saving life in an emergency.

With reference to the letter from Dr G R Park and others (18 April), I would point out that in their course of training chiropodists are taught all other usual resuscitation methods and indications for using them, but that in rare and crucial situations adrenaline may still be necessary. The course in local analgesia for State-registered chiropodists includes instructions in medical contraindications and in both local and general drug reactions. Consultant anaesthetists are involved in the teaching, and the society's examiners in local analgesia are approved by the Faculty of Anaesthetists.

The Society understands that under Article 5 of the Medicines (Prescriptions Only) Order 1980 chiropodists are permitted to administer adrenaline BP when the administration is for the purpose of saving life in an emergency; but Section 58 of the Medicines Act 1968 indicates that it can be supplied only "in accordance with a prescription given by an appropriate practitioner."

My society sincerely hopes therefore that it will have the support of the medical profession not only in the right of its members to use adrenaline injection BP in a life-saving emergency but also over the question of supply, whether this be in private practice or in the NHS.

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How dangerous are falls in old people?

SIR,—While it is possible that drop attacks occur on the basis of loss of Purkinje cells from the cerebellum, as Dr Irene P Rowlands suggests (9 May, p 1548), Brust *et al*¹ concluded from a detailed clinicopathological study that transient corticospinal tract ischaemia was a likely cause of these attacks. Their patient was a previously healthy 65-year-old man who had typical drop attacks over a five-day period with no concomitant objective neurological deficit. These were followed by bilateral strokes, from which he died.

Mean values (SD) for articular index, limbering-up time, pain on the visual analogue scale, functional index, and time taken to walk 50 ft in patients with rheumatoid arthritis and osteoarthritis on both the active green-lipped mussel extract (Seatone) and placebo, before and after three months' treatment

| | Rheumatoid patients | | Osteoarthritic patients | |
|--------------------------|----------------------------|---------------------|----------------------------|---------------------|
| | Active extract (n = 17) | Placebo (n = 11) | Active extract (n = 16) | Placebo (n = 22) |
| Articular index | | | | |
| Before | 15.5 (8.4) | 13.4 (6.7) | | |
| After | 8.6 (7.0) | 11.3 (10.3) | | |
| p Value: Wilcoxon | < 0.005 | NS | | |
| t test | < 0.05 | NS | | |
| Limbering-up time (min) | | | | |
| Before | 93.8 (70.0) | 106.4 (52.0) | 28.3 (25.6) | 24.0 (26.6) |
| After | 64.0 (13.0) | 96.0 (58.0) | 21.0 (18.5) | 23.5 (24.4) |
| p Value: Wilcoxon | < 0.01 | NS | NS | NS |
| t test | < 0.10 | NS | NS | NS |
| Pain ("") | | | | |
| Before | 55.9 (16.7) | 52.3 (16.1) | 58.8 (23.0) | 52.5 (23.5) |
| After | 47.0 (26.8) | 51.0 (19.8) | 40.2 (25.3) | 51.7 (25.6) |
| p Value: Wilcoxon | NS | NS | < 0.025 | NS |
| t test | NS | NS | < 0.05 | NS |
| Functional index | | | | |
| Before | 16.2 (14.0) | 12.4 (8.9) | 5.9 (2.5) | 6.0 (2.8) |
| After | 12.7 (6.1) | 11.7 (8.1) | 3.4 (3.1) | 5.6 (2.7) |
| p Value: Wilcoxon | < 0.005 | NS | < 0.005 | NS |
| t test | < 0.05 | NS | < 0.05 | NS |
| Time to walk 50 ft (min) | | | | |
| Before | 37.5 (20.0) | 31.7 (18.5) | 28.0 (8.3) | 26.8 (11.3) |
| After | 28.9 (13.6) | 28.3 (17.3) | 17.2 (5.0) | 25.6 (14.9) |
| p Value: Wilcoxon | < 0.005 | NS | < 0.005 | NS |
| t test | NS | NS | < 0.05 | NS |